

MISSOURI DIVISION OF HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

STATE OF PUBLIC HEALTH AND WELFARE

-61-040407

STATE FILE NUMBER

Registration District No. 69 Primary Registration District No. 4121 Registrar's No. 21

AMENDED

FILED DEC 11 1961

1. PLACE OF DEATH a. COUNTY <u>Christian</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Billings</u>		Length of stay in 1b <u>76 years</u>	c. CITY OR TOWN <u>Billings</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>no street address</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Marion</u> Last <u>Myers</u>			4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1885</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Common</u>		11. BIRTHPLACE (City and state or country) <u>Billings, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>David Myers</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Thompson</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Lillie Barrett, Billings, Missouri</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
DUE TO (b) <u>Arteriosclerosis</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pleural effusion</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from November 1961 to November 1961 and last saw ^{her} him alive on 28 Nov 1961
Death occurred at 8:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Karl Leidinger M.D.</u> (Degree or title)	22b. ADDRESS <u>Republic, Missouri</u>	22c. DATE SIGNED <u>1 Dec 61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/11/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Billings Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Jean Harris</u> ADDRESS <u>Clever, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 7, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Aline Hutter</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *John Harris*

Licensed Embalmer No. 4390

P. O. Address Clever, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.